ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

Date: September 23, 2016

To: Nicole Cupp-Herring, Chief Clinical Officer

From: Georgia Harris, MAEd
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AHCCCS Fidelity Reviewers

Method

On August 23 – 24, 2016, Georgia Harris and Karen Voyer-Caravona completed a review of the Lifewell South Central Assertive Community Treatment (ACT) team. This review is intended to provide specific feedback in the development of your agency's ACT services, in an effort to improve the overall quality of behavioral health services in Maricopa County.

At the time of the 2015 fidelity review, the South Central ACT team had just transitioned from a different provider to Lifewell Behavioral Wellness. Along with supportive case management and ACT services for SMI designated adults, Lifewell provides outpatient counseling, community living, vocational rehabilitation, residential treatment, transportation, and housing. Significant staff turnover challenged the ACT team prior to and since the transition in providers. For both June and July prior to this review, the ACT team had seven positions unfilled. The vast turnover rate may have compromised any practices implemented to improve fidelity in several areas identified for improvement in last year's review. As of August 9, 2016, the South Central ACT team had filled all 12 positions.

The individuals served through the agency are referred to as *clients, behavioral health recipients* and *members*, but for the purpose of this report, and for consistency across fidelity reports, the term "member" will be used.

During the site visit, reviewers participated in the following:

- Observation of a daily ACT team meeting;
- Individual interview with Team Leader/Clinical Coordinator (CC);
- Individual interviews with two Substance Abuse Specialists (SAS);
- Group interview with the Peer Support Specialist (PSS), Housing Specialist (HS), and the Employment Specialist (ES);
- Group interview with five members receiving ACT services;
- Charts were reviewed for ten members using the agency's electronic medical records system; and
- Review of agency documents: ACT Admission Screening Tool and ACT EXIT Criteria Screening Tool (developed by the RHBA), ACT marketing flyer, and Eight-Week Engagement Flow Chart.

The review was conducted using the Substance Abuse and Mental Health Services Administration (SAMHSA) ACT Fidelity Scale. This scale assesses how close in implementation a team is to the Assertive Community Treatment (ACT) model using specific observational criteria. It is a 28-item scale that assesses the degree of fidelity to the ACT model along 3 dimensions: Human Resources, Organizational Boundaries and the Nature of Services. The ACT Fidelity Scale has 28 program-specific items. Each item is rated on a 5-point scale, ranging from 1 (meaning *not implemented*) to 5 (meaning *fully implemented*).

The ACT Fidelity Scale was completed following the visit. A copy of the completed scale with comments is attached as part of this report.

Summary & Key Recommendations

The agency demonstrated strengths in the following program areas:

- The ACT team is fully staffed. The ACT team consists of an ACT Psychiatrist (a Locum Tenen or LT), two Nurses, a Team Leader/Clinical Coordinator, a Rehabilitation Specialist (RS), an Employment Specialist , a Housing Specialist , two Substance Abuse Specialists , an ACT Specialist (AS), an Independent Living Specialist (ILS), and a Peer Support Specialist. Caseload sizes are approximately nine members to every one staff member.
- The ACT team follows the written admission criteria provided by the Regional Behavioral Health Authority (RBHA); staff do not report pressure to accept individuals who do not meet the criteria, which may account for both lower rate of graduation and the low dropout rate.
- The ACT teams uses an eight week engagement strategy, which is available to staff in the form of a printed flow chart; it makes use of collaboration with both formal and informal support networks to re-establish contact with members who are difficult to locate, have missed scheduled appointments, or have not maintained contact with the team.
- The ACT team has a Peer Support Specialist (PSS) whose role and responsibilities are equal to those of rest of the staff members. The PSS is valued for his ability to build rapport with difficult to engage members.

The following are some areas that will benefit from focused quality improvement:

- The ACT team must stabilize the rate of staff turnover to no more than 20% over two years. The ACT team, agency, and the RBHA should collaborate to identify and find solutions to factors that contributed to a staff turnover rate of over 92% in the last two years. Many staff positions- including that of the CC, the Psychiatrist, the Nurses, the Substance Abuse Specialists, and the Peer Support Specialist- turned over multiple times and/or remained unfilled for months. High staff turnover is universally understood to be a significant barrier to trust and rapport required for effective therapeutic relationships, and may be a factor contributing several challenging areas in the current review.
- The agency and the RBHA should provide ongoing education, training, and mentoring necessary to implement the ACT model and for ACT staff to function in the respective areas of specialization; specialists should have the professional skills, competencies and confidence to provide cross-training to the other specialists on the team, so that all staff can respond to member needs immediately. Education and training should prioritize the roles of the SAS and vocational specialists.
- The agency and the RBHA should ensure that all ACT staff are fully-versed in the dual-disorders model, receiving ongoing training and feedback/coaching in their implementation of non-confrontational, stage-wise interventions such as Motivational Interviewing, harm reduction strategies, strength based and person-centered goal setting, and cognitive behavioral techniques.

- The ACT team and the agency should identify and implement solutions to increasing the frequency and intensity of community-based services with members. The ACT team should avoid clinic- located interventions and groups, other than those specifically described within the EBP of ACT (e.g. substance abuse groups). Rather than focusing on a minimum of four contacts totaling two hours per week for each member, the team should redirect efforts to providing meaningful engagements, geared toward assisting members' individualized goals and objectives. Frequency and intensity across the whole team should *average* four contacts, and two hours per week, with some members receiving less or substantially more based on current needs.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	One hundred members are served by 11 ACT staff (excluding the Psychiatrist) for a member/staff ratio of 9:1.	
	Team Approach	1 – 5 3	Each ACT staff member, excluding the Psychiatrist and the two Nurses, has a monthly calendar with a daily list of eight to ten members they are responsible for seeing. The list rotates daily and may be subject to further change due to immediate member needs, crisis, or travel time requirements. Said one staff member, "You always have to be flexible . . . if I miss someone, I hop over to the next day and try to get everyone in that week." The CC estimated less than 60% of members see more than one staff member in a two week period. Members interviewed reported that they usually see between 4 – 5 different staff members each week. A review of ten randomly selected member records showed that 50% of members were seen by more than one member in a two week period. Reported difficulties in timely documentation of contacts in the electronic records may account for this discrepancy. Additionally, the ACT team was not fully staffed during the period identified for sampling.	• The ACT team should ensure that 90% of members see more than one staff member in a two week period. Maintaining full staffing and timely entry of contacts in member records may support efforts in this area.
H3	Program Meeting	1 – 5 4	According to the CC, the ACT team meets to review all members in the program meeting Tuesday through Friday. The meetings last approximately 1.5 hours, but the meeting observed lasted 1.75 hours. Also, on Mondays, the team meets for about 30 minutes to discuss significant issues or follow-up on events that occurred over the weekend. Staff work four, ten-hour schedules, allowing most to attend daily meetings throughout the week, and the	• The ACT team should minimize the completion of administrative tasks in program meeting that distract from the team's focus on member needs and concerns, solve problems and engage in person-centered planning and recovery oriented rehabilitation efforts.

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			Psychiatrist attends all meetings except for Monday. The Program Assistant expedited the meeting observed; although all members were discussed, considerable time was expended upon administrative tasks. For each member discussed, staff first reported the service provided and time spent for each member. Independent living skills and medication observations were the dominant services provided. The reviewers heard little mention of substance abuse treatment or work goals, and the meeting lacked a recovery focus. One staff interviewed said that this was representative of a usual meeting. .	
H4	Practicing ACT Leader	1 – 5 3	The CC said that he is expected to spend 50% of his time in direct member service through such activities as med observations, clinic walk-ins, and hospital discharge planning. The CC said that he achieves this goal but struggles to get his documentation entered in a timely manner. He attributes this to time spent traveling between members' residences and hangouts, attending meetings, performing administrative tasks, and dealing with crisis situations. However, he reported that the agency has recently designated an additional support person to transcribe staff notes from recorded dictation. The CC thinks this has been helpful. Although the reviewers requested the CC's encounter report, one was not provided. The record review showed that out of 1707 minutes of contact between staff and members, the CC was responsible for 109 minutes (6%). The majority of those contacts occurred in the community providing medication observations.	• The CC should provide direct member services 50% of the time, and ensure timely documentation in member records. • The CC and the agency should identify any administrative functions not essential to the CC's time that could be performed by the program assistant or other administrative staff to free up time for direct member services, including shadowing and mentoring staff in delivery of community-based services.

Item #	Item	Rating	Rating Rationale	Recommendations
H5	Continuity of Staffing	1 – 5 1	The agency did not provide complete data on continuity of staff due in part to the team's recent transition from another provider. When asked about the discrepancies in the staff tenure dates provided, the CC explained that most staffing changes preceded his arrival, and the dates provided were furnished by the HR department. However, the reviewers were able to reconcile the timeline inconsistences. Even with this correction, it is possible that the information remains incomplete since it is unclear if the agency accounted for temporary staff placed in some positions. In the two years preceding the review, the reviewers found that 34 individuals worked in 12 positions on the ACT team. During that time, 22 staff members left, for a turnover rate of 92%. Every position has turned over at least one time, and most positions have turned over at least twice and/or remained unfilled for months. Staff interviewed reported high staff turnover seemed to lead to still more turnover, as staff become exhausted due to chronically operating in crisis mode, negatively affecting trust and rapport building with members. Said one staff member, "If they don't know you, they don't open the door."	• The ACT team should maintain consistent staff over time for a turnover rate of no more than 20% in two years. Continuity of staffing is essential for promoting trust, therapeutic relationships, staff cohesion, and for maximizing the benefits of specialty training and other professional developments efforts. • The agency should identify contributing factors to high staff turnover and work to find solutions. Consider anonymous employee satisfaction survey and exit interviews in order to gather and analyze feedback on why staff leave, as well as factors that promote retention.
H6	Staff Capacity	1 – 5 3	Based on data provided by the agency, in the past 12 months preceding the review, the sum total of vacancies was 42, indicating that ACT team operated at 71% capacity.	• Maintain staffing; see recommendation for item H5, Continuity of Staffing.
H7	Psychiatrist on Team	1 – 5 5	The ACT team has a full-time Psychiatrist to treat 100 members. He is one of several temporary doctors or locum tenens to have worked on the ACT team during the last year. The Psychiatrist works four ten-hour days, taking Monday as his flex day. Staff described him as accessible, a "team player", who works to build rapport with	• The agency should hire a permanent, full-time Psychiatrist.

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			providers in inpatient facilities, and is willing to see members in the community. It was reported that the Psychiatrist only sees individuals assigned the ACT team, and has no responsibilities outside the ACT team.	
H8	Nurse on Team	1 – 5 5	Two Nurses serve the ACT team full-time. One nurse is a temporary contractor. Both Nurses work four ten-hour days, with one taking a flex day on Monday and the other on Friday. Staff described both Nurses as accessible and flexible; they are willing to see members in the community to deliver medications, provide injections, and perform blood draws. Neither Nurse sees members from other teams or has responsibilities outside the ACT team.	
H9	Substance Abuse Specialist on Team	1 – 5 3	The ACT team has two Substance Abuse Specialists (SAS). SAS(1) joined the team at the end of May and is a Licensed Associate Counselor (LAC). It was not clear what specific training the SAS(1) has in treatment for substance abuse; however, he has more than a year of experience working with individuals with substance abuse (including a graduate-level internship) and some professional experience working on both inpatient SMI and substance abuse units. SAS(2) joined the ACT team in late June, coming from Lifewell's housing program. She reported that she has worked for 15 years in behavioral health but has not had specific training in substance abuse, and her familiarity with substance abuse treatment appeared very limited. She reported that she previously worked in a support role with a hospital Substance Abuse Counselor, connecting people with services, co-facilitating treatment groups, and accompanying	• The agency and the RBHA should provide the SAS(2) with the necessary training and clinical oversight to perform all the functions of the SAS position, including cross-training other staff.

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			clients to 12-step support groups. She said she is currently taking a certification course in substance abuse counseling through Maricopa Community College. It was not clear to the reviewers how the SAS(2) is or will be functioning in this role or what the division of responsibility is or will be between the two SASs. At the time of the review the team was not providing any individual substance abuse treatment.	
H10	Vocational Specialist on Team	1 – 5 1	The ACT team hired the Rehabilitation Specialist in late June and the Employment Specialist in late July. Previous to joining the ACT team, the ES worked as a case manager on a supportive team, although he reported having prior ACT team experience. The CC said the RS previously worked in residential treatment and had a "rehab" role; though the reviewers later sought clarification on what this meant, the CC did not provide further information. It was not clear to the reviewers what trainings, if any, either the ES or the RS have received for their positions.	• The agency and the RBHA should provide the ES and the RS with the necessary training, mentoring and networking experiences for them to fully function in their roles as vocational specialists, including providing cross-training to other specialists on the team.
H11	Program Size	1 – 5 5	All 12 positions on the South Central ACT team are filled, and the team is sufficiently diverse. Two positions, that of the ACT Psychiatrist and one Nurse, are filled with full-time, temporary staff.	• For long-term team cohesion, the agency should recruit and fill the Psychiatrist and Nurse positions with full-time, permanent staff. • See recommendation for item H5, Continuity of Staffing.
O1	Explicit Admission Criteria	1 – 5 5	The ACT team uses the written ACT admission criteria provided by the RHBA. The CC and other staff interviewed described the admission criteria as based on an SMI diagnosis, with significant functional impairment, homeless status or high risk for homelessness, frequent use of crisis	

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			services/emergency room/psychiatric hospitalizations, a co-occurring substance abuse disorder, and poor response to traditional case management services. The CC reported no pressure to accept referrals outside the admission criteria and described having rejected a referral recently because the primary issue appeared to be only difficulty performing independent living skills.	
O2	Intake Rate	1 – 5 5	The ACT team admitted six members in the last six months. The highest intake occurred in July when two members were admitted. The CC reported the team's census is fairly stable and usually keeps a waitlist.	
O3	Full Responsibility for Treatment Services	1 – 5 3	Along with case management, the ACT team is fully responsible for psychiatric services, and housing support. The Psychiatrist has contacted other treating Psychiatrists directly if he learns of a duplication of service; sometimes this involves discussions with guardians. Although the team reported that approximately 7% of members live in situations with some level of staff support (supervised care homes (2), assisted living (2), 24-Central Arizona Shelter Services (2), and 24-hour residential (1)), staff said the ACT team provides case management and other support services. The individual in 24-hour residential is on a 30-day transition to a supportive team. While the staff report the ACT team offers counseling psychotherapy, employment services, and substance abuse treatment, the reviewers did not find evidence in the records and interviews that the team provides the services as indicated. Based on the reviewers' observation of the team meeting it was not clear that staff actively engage members in discussions about those services. The	• The ACT team should continue efforts to launch substance abuse treatment services, including individualized and group treatment in order to reduce/eliminate reliance on outside treatment providers such as residential treatment and detox. Both SASs should be trained and provided the clinical oversight to fully function in their roles and provide cross training to staff in other specialties. • The agency and the RBHA should immediately begin providing the ES and RS with training and mentoring necessary to for the team to assume full responsibility for vocational services. • Maintain continuity of staffing to support therapeutic rapport necessary for successful engagement in recovery oriented services. See recommendations for H4, Continuity of Staffing.

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			SAS(1) is licensed to provide counseling psychotherapy and is currently providing that service to only one member. The ES, who joined the team one month before the review, said he is working with approximately eight members. However, he has no background in vocational services nor has he received any training for the specialty position. Though five members currently hold jobs, prior to the ES being hired, the ACT team had referred to outside providers. One individual receives services at Focus. Staff interviewed described the substance abuse program, both individualized and group treatment, as "under development". It was not clear to the reviewers whether or not groups facilitated by the SAS(1) were specific to substance abuse. Staff reported one member is receiving substance abuse treatment from an outside provider, and that a few people who have been attending a substance abuse day-treatment program at a local hospital are being transitioned to the SAS(1). The ACT team's difficulty in achieving fidelity in this area may be partly attributed to the team being chronically short on staff for more than a year. As one specialist said, "When we were a short team, it was back to back crisis . . . members had more needs than we had people to respond . . . the workload was unbearable."	
O4	Responsibility for Crisis Services	1 – 5 4	The CC said that the ACT staff are the first point of contact for members in crisis and available 24 hours a day, seven days a week. The on-call phone rotates every seven days (Wednesday to Wednesday) but members are given brochures about crisis response with all staff contact info.	• The team should build trust and rapport with members and educate them on how ACT staff can assist them in managing crisis situations. • Trust and rapport building should extend to

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			Members often contact the staff person with whom they have the strongest rapport. The CC is the on-call backup. Some members call the crisis line, but the crisis line staff will redirect calls the ACT team. While the ACT team does offer crisis service and provides information for members on how to access staff when in distress, the low rate of team involvement in psychiatric hospitalizations indicates the team is not yet fully responsible.	members' informal supports, and the team should have regular discussions with members regarding the benefits of allowing ACT staff to communicate with their informal support network.
O5	Responsibility for Hospital Admissions	1 – 5 2	Although data provided to the reviewers prior to the review indicated that the ACT team was involved in 100% of the last psychiatric hospitalizations, that data was not completed accurately. After discussing the last ten psychiatric hospitalizations conducted with the CC, the reviewers found that the ACT team was only involved in 30% of them. Staff interviewed reported that members often self-admit, and family members may also hospitalize members and notify the team afterward. Per the record review, one record showed that a member had been hospitalized and discharged without the team's knowledge. Another record found that the team learned of a member's hospitalization at some point after admission. High staff turnover, which can compromise trust and rapport in the therapeutic relationship, may have contributed to the low rate of ACT team involvement in admissions.	• The ACT team should be involved in all member admissions to psychiatric hospitals. The ACT team and the agency should identify and find solutions to factors resulting in psychiatric hospital admissions without the ACT team's knowledge and/or involvement. • Maintain consistent and full staffing to support rapport and trust between members and staff so that members seek out staff when they are in crisis or concerned about symptoms. With therapeutic rapport, staff are better able to recognize warning signs indicating that a member is approaching or in crisis. • Ensure that members' informal supports understand their role as part of the team. Explain the importance of involving the ACT team in decisions to hospitalize members and how to contact the ACT team when members are in or approaching crisis. • See recommendation for S6, Working With Support Systems.
O6	Responsibility for Hospital Discharge Planning	1 – 5 5	Of the last ten psychiatric hospitalizations reviewed with the CC, the reviewers found that the ACT team was involved in 100% of them. Staff	

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			report that the team is involved in discharge planning from the point of admission. Upon discharge, the team will transport members from the facility to their home and schedule follow up appointments with the Psychiatrist. Evidence of this occurring was found in member records.	
O7	Time-unlimited Services	1 – 5 5	The ACT team graduated five members (5%) in the last 12 months and expects to graduate another two within the next year. The team provides time-unlimited services and uses an exit criteria screening tool developed by the RBHA when considering discharge. The checklist prompts the staff and the member to consider lack of psychiatric hospitalizations; utilization of crisis services; involvement in the criminal justice system; attendance to scheduled appointments and medical needs; housing stability and demonstration of unprompted self-care and independent living skills; and community integration such as holding down employment and engagement with social supports. Members are monitored for 30 days prior to transitioning off the team, with reduced contacts with staff and limited phone contact that replicates that of a supportive team. Regardless, ACT members can elect to remain on the team if they prefer.	
S1	Community-based Services	1 – 5 2	Though most staff interviewed estimate that they spend 70% - 80% of their time delivering community based services, a review of ten member records showed the rate to be 33%. Staff report they have been challenged to document member contact in a timely basis, possibly accounting for the discrepancy staff report and the clinical records. Some staff may rely on clinic-based contacts to	• Increase delivery of community-based member services to 80%. Focus on the timely documentation to accurately reflect member engagements, and consider solutions developed by ACT teams that score well in this area. • Rather than encourage members to come to the clinic, staff should focus on providing community-based services where staff can

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			help them attain encounter expectations; staff interviewed discussed plans for clinic based programming, in addition to co-occurring groups.	more effectively assess, monitor, and assist in problem solving and skill building. Avoid implementation of site-based groups not specifically referred to in the evidenced-based ACT protocol.
S2	No Drop-out Policy	1 – 5 5	According to interviews and the provided data, the ACT team retained 96% of its membership over the last 12 months. One member left the team after he and his guardian determined that placement in a residential facility would best meet both his mental and physical health needs. Three members left the geographic area without notifying the team; one of the three went to live with family out-of-state. Staff said that few members are closed because most eventually make contact with the team when they have a concern such as housing, medication, or some other need.	
S3	Assertive Engagement Mechanisms	1 – 5 5	Staff described using an eight-week outreach strategy with members who have missed appointments and have been out of contact with the ACT team. A copy of the strategy was provided to the reviewers. Staff said that they collaborate with members' formal (e.g., primary care doctors, probation officers, payees, etc.) and informal support network in order to make contact with difficult-to-reach members. Evidence of this was found in some member records. The CC said that they have even located one member, who had gone out of state without notifying the team, through his Facebook posts. Staff said that they also check hospital emergency rooms, the morgue, known hangouts, CASS, and jails in attempt to locate members.	
S4	Intensity of Services	1 – 5	The review of ten member records showed that	• The ACT team should provide members an

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		2	members receive an average of 32 minutes a week of contact from staff. Progress notes indicated that many of the contacts made in the home were very brief check-ins, monitoring ILS skills, or medication observations; some contacts lasted as little as four minutes.	average of two hours of face-to-face contact each week. Intensity may vary based on where the member is in recovery, but an average of two hours across the team should be the goal. Contacts should be person-centered, based on needs, and delivered in the community to best promote skill building and new knowledge (see recommendation for item S1, Community-based Services).
S5	Frequency of Contact	1 – 5 3	While members interviewed said that they see between 4 and 7 different staff on any given week, the record review showed the average number of member contacts with staff was 2.13 per week. Lack of timely service documentation may account for this discrepancy.	• The ACT team should provide members with an average of 4 contacts per week. Contacts should be purposeful, person-centered, and recovery oriented (see recommendations for items S1, Community-based Services, and S4, Intensity of Services).
S6	Work with Support System	1 – 5 2	Reported estimates for the number of members with actively involved informal supports varied between staff, for an average of 84%. Staff reported that they have contact with an average of 75% (63 members) of those informal supports in any given month. Staff said that most contacts are by phone and that some supports, usually family members, come to the clinic to discuss issues or concerns. However, the reviewers recorded only two or three mentions of contacts with informal supports during the team meeting. The record review found that staff have less than one contact (.60) for each member with a support system. The score for this item reflects the staff report, the morning meeting, and record review combined.	• The ACT team should have four or more contacts per month with informal supports, for each member with a support system. Staff should discuss with members the benefits of allowing contact with their informal supports. • ACT staff should regularly talk with members about the benefits of allowing staff to have contact with informal supports; obtain current Release of Information/ Authorization to Use and Disclose (ROI/AUD) forms and provide regular outreach to support the spirit of collaboration/cooperation. • Staff should regularly check in with informal supports where appropriate to encourage their role as allies in recovery; to provide useful psychoeducation about

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				symptoms and behaviors; and to obtain their feedback on members' functioning/needs/progress. • The CC should clarify with staff the parameters surrounding documentation of information provided by informal supports, and its relationship towards fidelity in this area.
S7	Individualized Substance Abuse Treatment	1 – 5 1	At the time of the review, no members were reported to be receiving individualized substance abuse treatment from either of the SASs. According to the SASs and the CC, the substance abuse program is still in development; the SAS(1) is focused on rapport building and offering one-on-one substance abuse treatment with members already engaged in substance abuse groups. The CC reported that only the SAS(1) will be providing the individualized substance abuse treatment because he is a Licensed Associate Counselor. It was not clear to the reviewers what role the SAS(2) would play in the provision for this service but she currently does not have the necessary training and experience.	• The team should ramp up efforts to outreach and engage members with a co-occurring disorder in individualized substance abuse treatment. Consider using examples of other peers who have benefitted from treatment. • Do not limit substance abuse treatment to the Licensed Associate Counselor on the team. The fidelity protocol only requires that counseling be performed by a staff with at least one year training and experience in substance abuse treatment. • Provide both SASs with ongoing training and mentoring in the principles of the co-occurring model/stage-wise approach with an emphasis on motivational interviewing. • Develop and implement a training timeline for the SAS(2) so that she is able to fully carry out the functions of the SAS role.
S8	Co-occurring Disorder Treatment Groups	1 – 5 2	Staff interviewed did not provide consistent reports regarding the focus of the substance abuse treatment groups. Some staff identified the co-occurring groups as substance abuse specific. One staff described them as wellness groups that focused on stages of change, harm reduction, and progress.	• Treatment groups should be specific to substance abuse treatment for individuals living with an SMI, and organized around the dual disorders model. • Staff should enhance effort to recruit members to attend co-occurring treatment groups. Ongoing training, including cross

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			Currently, two groups facilitated by the SAS(1) are provided at the clinic during the week, on Mondays and Wednesdays. The groups are new programming and have between four to six attendees at each weekly. Per interview, ten (16%) of the 61 members identified with a co-occurring disorder attend at least one group per month. One SAS said that there are a lot of "no-shows" to the group because "people with schizophrenia are difficult to engage". The team is also in the process of setting up Monday and Tuesday ACT specific groups at the Lifewell Beryl and Mitchell Street hubs; transportation will be provided to encourage attendance. The SAS(1) does not follow a specific curriculum or treatment model, but reports using the "five stages of change model" (transtheoretical model) alongside some cognitive behavioral approaches. The reviewers did not find evidence of substance abuse groups in the record review to verify this report.	training by the SASs, for all staff specialists in the dual diagnosis model may increase member engagement in co-occurring groups (see recommendations for item S9, Co-occurring Disorders Model). • Clinical oversight, supervision, and mentoring should be provided to SASs and other specialists to assist them in helping members find internal motivation for engagement in substance abuse treatment groups and challenge deficit-based approaches and stigmatizing stereotypes about people living with an SMI as resistant to treatment.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 2	The CC said the expectation is that ACT will use evidence based practices such as the stage-wise treatment approach and motivational interviewing. The CC stated that the ACT team is still learning how to apply the stage-wise treatment approach in their documentation. He said that he does not see it consistently implemented, attributing this to the team being so new with many staff yet to be exposed to it. While most staff interviewed described abstinence is more of an ideal than a reality, the CC said that some staff lack a complete understanding of the harm reduction philosophy and have yet to embrace tactics such as providing resource for obtaining clean needles or encouraging use of less	• The agency and RBHA should provide education and training to all ACT staff on a dual disorder model, such as Integrated Treatment for Co-Occurring Disorder, the stage-wise treatment approach, and motivational interviewing. Training should be ongoing to accommodate for new and less experienced staff. Standardizing a basic tenant of treatment may help ensure consistent interventions across the system.

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			lethal substances. Reviewers were able to confirm this assessment across staff interviews, observing the team meeting, and by a review of progress notes. Many staff reported having received little or no trainings relevant to ACT or the co-occurring model since joining the team, and several of the staff have no previous experience on an ACT team.	
S10	Role of Consumers on Treatment Team	1 – 5 5	The ACT team has a Peer Support Specialist (PSS), who was described as "passionate" about helping people in recovery, eager, and motivated by the belief that people can change their lives with support. The PSS is considered a full member of the team with equal responsibilities.	
Total Score:		**3.43**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	5
2. Team Approach	1-5	3
3. Program Meeting	1-5	4
4. Practicing ACT Leader	1-5	3
5. Continuity of Staffing	1-5	1
6. Staff Capacity	1-5	3
7. Psychiatrist on Team	1-5	5
8. Nurse on Team	1-5	5
9. Substance Abuse Specialist on Team	1-5	3
10. Vocational Specialist on Team	1-5	1
11. Program Size	1-5	5
Organizational Boundaries	Rating Range	Score (1-5)
1. Explicit Admission Criteria	1-5	5
2. Intake Rate	1-5	5
3. Full Responsibility for Treatment Services	1-5	3
4. Responsibility for Crisis Services	1-5	4
5. Responsibility for Hospital Admissions	1-5	2

6. Responsibility for Hospital Discharge Planning	1-5	5
7. Time-unlimited Services	1-5	5
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	2
2. No Drop-out Policy	1-5	5
3. Assertive Engagement Mechanisms	1-5	5
4. Intensity of Service	1-5	2
5. Frequency of Contact	1-5	3
6. Work with Support System	1-5	2
7. Individualized Substance Abuse Treatment	1-5	1
8. Co-occurring Disorders Treatment Groups	1-5	2
9. Co-occurring Disorders (Dual Disorders) Model	1-5	2
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.43**	
Highest Possible Score	**5**	